

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DSTL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245045		3. NAME AND ADDRESS OF FACILITY (L3) SUNNYSIDE HEALTH CARE CENTER			4. TYPE OF ACTION: <u>2</u> (L8)																
2.STATE VENDOR OR MEDICAID NO. (L2) 695045102		(L4) 512 SKYLINE BOULEVARD			1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 8. Full Survey After Complaint 9. Other																
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE			FISCAL YEAR ENDING DATE: (L35) 09/30																
6. DATE OF SURVEY 03/29/2018 (L34)		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: ___ 1. Acceptable POC ___ 2. Technical Personnel ___ 3. 24 Hour RN ___ 4. 7-Day RN (Rural SNF) ___ 5. Life Safety Code ___ 6. Scope of Services Limit ___ 7. Medical Director ___ 8. Patient Room Size ___ 9. Beds/Room																			
8. ACCREDITATION STATUS: ___ (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)																			
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		14. LTC CERTIFIED BED BREAKDOWN <table border="1"> <tr> <td>18 SNF</td> <td>18/19 SNF</td> <td>19 SNF</td> <td>ICF</td> <td>IID</td> </tr> <tr> <td></td> <td>44</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(L37)</td> <td>(L38)</td> <td>(L39)</td> <td>(L42)</td> <td>(L43)</td> </tr> </table>			18 SNF	18/19 SNF	19 SNF	ICF	IID		44				(L37)	(L38)	(L39)	(L42)	(L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
18 SNF	18/19 SNF	19 SNF	ICF	IID																	
	44																				
(L37)	(L38)	(L39)	(L42)	(L43)																	
12.Total Facility Beds 44 (L18)		13.Total Certified Beds 44 (L17)																			

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Kathie Siemsen, HFE - NE II	Date : 04/19/2018	18. STATE SURVEY AGENCY APPROVAL Alison Helm, Enforcement Specialist	Date: 05/04/2018
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY ___ 1. Facility is Eligible to Participate ___ 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT: ___		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : ___	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1967 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> 00 <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28)		30. REMARKS DETERMINATION APPROVAL	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 13, 2018

Mr. Jeffrey Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

RE: Project Number S5045028

Dear Mr. Brown:

On March 29, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

**Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359**

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 8, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 8, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 29, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 29, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

Sunnyside Health Care Center

April 13, 2018

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St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2018
NAME OF PROVIDER OR SUPPLIER SUNNYSIDE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 SKYLINE BOULEVARD CLOQUET, MN 55720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
F 000	<p>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 3/26/18 through 3/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.</p> <p>INITIAL COMMENTS</p> <p>On 3/26/18 - 3/29/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form.</p> <p>Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.</p>	F 000			
F 732 SS=C	<p>Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and</p>	F 732		4/17/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/19/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 732	<p>Continued From page 1</p> <p>unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the daily nursing hours posting included the actual hours worked by licensed and unlicensed staff. This had the potential to affect all 42 residents who resided in the facility.</p> <p>Findings include:</p>	F 732	<p>Sunnyside Health Care Center does post Nurse Staffing Information at the beginning of each shift.</p> <p>The Posted Nurse Staffing Information has been corrected effective 4/17/2018 to include all of the data requirements; facility name, current date, total number and the actual hours worked by the</p>		

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F 732	Continued From page 2 Review of the Nurse Staffing Information from 2/1/18, through 3/27/18, indicated the daily nursing hours posted lacked the actual hours worked by licensed and unlicensed staff. On 3/28/18, at 8:45 a.m. the Nurse Staffing Information was posted on the wall outside of the main dining room. The Nurse Staffing Information dated 3/28/18, lacked the actual hours worked by licensed and unlicensed staff. On 3/28/18, at 10:00 a.m. the director of nursing (DON) verified the Nurse Staff Posting lacked actual hours worked. The facility's Posted Nurse Staffing Information policy dated 11/17, directed the form would include the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care each shift.	F 732	following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, Certified nurse aides. Resident census. The Posted Nurse Staffing Information policy and procedure was reviewed effective 4/17/18. RN Supervisors and Managers were educated on the data requirements of the Posted Nurse Staffing Information on 04/17/18. Monitoring will be done daily x2 weeks, weekly x1 month, and monthly x6 to ensure accuracy. The correction will be monitored by the DON and Administrator to ensure compliance. Any issues and/or concerns in regards to the audits will be brought to our Resident Care Team meeting on a monthly basis. Results of the Posted Nurse Staffing Information audits will be brought to our quarterly QAA meeting for review and recommendations.		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		4/23/18	

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F 880	<p>Continued From page 3</p> <p>development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p>	F 880			

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F 880	<p>Continued From page 4</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have an accessible infection control program. In addition, the facility failed to ensure a comprehensive policy and procedure was developed for Legionella (a bacteria that can cause Legionnaires' Disease, a very serious type of pneumonia) that specified testing protocols, acceptable ranges, precautions and prevention of outbreaks. This had the potential to affect all 42 residents residing in the facility.</p> <p>Findings include:</p> <p>On 3/29/18, at 2:09 p.m. the director of nursing (DON) was interviewed and stated she was unable to access the infection control data tracking files. The DON stated only registered</p>	F 880	<p>Sunnyside Health Care Center does have and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>All residents (42/42) have shown no signs and symptoms of respiratory illness.</p> <p>In the event that our Infection Control/Preventionist is absent, there will be two designee(s) who will have access to the infection control data tracking files at all times. The designee(s) will be the DON and Pharmacist. This was</p>		

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F 880	<p>Continued From page 5</p> <p>nurse (RN)-C had access to the infection control data, and she was on vacation. The DON stated RN-C collected and tracked all infection control information. The DON was unable to produce documentation of tracking and trending infections for the facility. The DON confirmed no facility staff was able to access the infection prevention/infection control data during the survey 3/26/18, through 3/29/18.</p> <p>On 3/29/18, at 2:11 p.m. the director of buildings and grounds (DBG) stated he used the Centers for Disease Control and Prevention toolkit to come up with the Water Management Policy, dated 2/12/18. The DBG stated he was aware the policy identified areas where water could be standing, and thus be at risk for developing Legionella. The DBG confirmed the policy lacked direction regarding a plan for testing, acceptable ranges, precautions and prevention of outbreaks.</p> <p>The facility Water Management Program Policy dated 2/12/18, included the following information regarding Legionella : Areas of concern for Legionella: ice machines, sinks/showers/bath tub, water heaters, hot water storage, and kitchen appliances. Control Measures and Corrective Actions: appropriate hot water temperatures are maintained, temperatures to be monitored and documented twice a year, humidifier pans will be monitored and documented twice a year to ensure an abundance of water is not sitting in the drip pans. This data will be reported at the quarterly Infection Control Committee meetings</p> <p>The Water Management Program policy lacked specific directives for testing protocols, control measures and acceptable ranges for control measures. The policy also lacked direction for</p>	F 880	<p>implemented on 04/18/2018.</p> <p>The Infection Control Program policy and procedure was reviewed and updated on 04/18/2018 to reflect the designee(s).</p> <p>All staff will be educated regarding the assigned designee(s) and revision to the policy and procedure.</p> <p>Sunnyside Health Care Center does have a Water Management Program policy and procedure that includes a section on Legionella.</p> <p>The Director of Building and Grounds has been in contact with a water treatment company (Freemont Industries)to come in and take samples of our water system which will then be tested for the Legionella bacteria. Also, they will be involved with the development of a plan in the event that Legionella bacteria is present. The Water Management Program policy and procedure has been reviewed and will be updated to reflect an appropriate mitigation plan should Legionella be found in our water.</p> <p>The Director of Building and Grounds shall be responsible.</p> <p>The appropriate staff will be educated on the changes with the policy and procedure by the DON.</p> <p>The correction will be monitored by the Administrator, and Director of Nursing.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2018
NAME OF PROVIDER OR SUPPLIER SUNNYSIDE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 SKYLINE BOULEVARD CLOQUET, MN 55720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 6 precautions and prevention of outbreaks.	F 880	The results will be reported annually to the Infection Control Committee and to the LTC QAA by the Director of Building and Grounds, which the DON and Administrator attend. Issues and/or concerns will be reported immediately to Infection Control/Preventionist and the Director of Building and Grounds.		

75045026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245045	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2018
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NAME OF PROVIDER OR SUPPLIER SUNNYSIDE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 512 SKYLINE BOULEVARD CLOQUET, MN 55720
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Sunnyside Health Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>Sunnyside Care Center, is a 3-story building with no basement. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968 the second floor was added, also Type II(111) construction. In 2000 dining rooms were constructed on floors one and two of Type II(111) construction. In 2012/2013 a 3 story building with a full basement, Type I (332) construction was added. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. This skilled nursing home is not 2 hour fire rated separated from the attached hospital, and the hospital was also inspected. The nursing home beds are all located on the 2 story of the building.</p> <p>The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 13, 2018

Mr. Jeffrey Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

Re: State Nursing Home Licensing Orders - Project Number S5045028

Dear Mr. Brown:

The above facility was surveyed on March 26, 2018 through March 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Sunnyside Health Care Center

April 13, 2018

Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Teresa Ament, Unit Supervisor, at (218) 302-6151 or teresa.ament@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2018
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NAME OF PROVIDER OR SUPPLIER SUNNYSIDE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 512 SKYLINE BOULEVARD CLOQUET, MN 55720
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota</p>	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE
04/19/18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2018
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NAME OF PROVIDER OR SUPPLIER SUNNYSIDE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 512 SKYLINE BOULEVARD CLOQUET, MN 55720
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2 000	<p>Continued From page 1</p> <p>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>On March 26, 2018, through March 29, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.</p> <p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p>	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		5/3/18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2018
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21375	<p>Continued From page 2</p> <p>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have an accessible infection control program. In addition, the facility failed to ensure a comprehensive policy and procedure was developed for Legionella (a bacteria that can cause Legionnaires' Disease, a very serious type of pneumonia) that specified testing protocols, acceptable ranges, precautions and prevention of outbreaks. This had the potential to affect all 42 residents residing in the facility.</p> <p>Findings include:</p> <p>On 3/29/18, at 2:09 p.m. the director of nursing (DON) was interviewed and stated she was unable to access the infection control data tracking files. The DON stated only registered nurse (RN)-C had access to the infection control data, and she was on vacation. The DON stated RN-C collected and tracked all infection control information. The DON was unable to produce documentation of tracking and trending infections for the facility. The DON confirmed no facility staff was able to access the infection prevention/infection control data during the survey 3/26/18, through 3/29/18.</p> <p>On 3/29/18, at 2:11 p.m. the director of buildings and grounds (DBG) stated he used the Centers for Disease Control and Prevention toolkit to come up with the Water Management Policy, dated 2/12/18. The DBG stated he was aware</p>	21375	Corrected.	

Minnesota Department of Health

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21375	<p>Continued From page 3</p> <p>the policy identified areas where water could be standing, and thus be at risk for developing Legionella. The DBG confirmed the policy lacked direction regarding a plan for testing, acceptable ranges, precautions and prevention of outbreaks.</p> <p>The facility Water Management Program Policy dated 2/12/18, included the following information regarding Legionella : Areas of concern for Legionella: ice machines, sinks/showers/bath tub, water heaters, hot water storage, and kitchen appliances. Control Measures and Corrective Actions: appropriate hot water temperatures are maintained, temperatures to be monitored and documented twice a year, humidifier pans will be monitored and documented twice a year to ensure an abundance of water is not sitting in the drip pans. This data will be reported at the quarterly Infection Control Committee meetings</p> <p>The Water Management Program policy lacked specific directives for testing protocols, control measures and acceptable ranges for control measures. The policy also lacked direction for precautions and prevention of outbreaks.</p> <p>SUGGESTED METHOD FOR CORRECTION:</p> <p>The director of nursing (DON) or designee could review and/or revise the current infection control policies and procedures to ensure the infection control policies, procedures and program is available at all times. The admisistrator or designee could review and/or revise the Legionella policy and procedure.</p> <p>The DON, administrator or designee could educate the appropriate staff on the policies/procedures.</p>	21375		

Minnesota Department of Health

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21375	Continued From page 4 The DON, administrator or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		